N.D. Department of Human Services
SFN 407 (Rev. 06-05)

☐ **REDETERMINATION FOR HEALTH CARE COVERAGE**
☐ **FOOD STAMP RECERTIFICATION**

FOR OFFICE USE ONLY
Date Received:
Date Interviewed:
Person Interviewed:

IMPORTANT: DO NOT COMPLETE, DATE, OR SIGN BEFORE THE 1ST OF THE MONTH

CASE NUMBER:	**RETURN COMPLETED FORM TO:** **Telephone:**

REDETERMINATION FOR HEALTH CARE COVERAGE: This form is used to determine continued eligibility for Health Care Coverage. Read and answer all questions carefully. You may have a friend, relative, or the county social service agency help you complete this form. This redetermination is for .
IT MUST BE COMPLETED, SIGNED, AND RETURNED TO THE OFFICE ABOVE BY .
Failure to return the form and required verifications on time may result in your case being closed effective .

FOOD STAMP RECERTIFICATION: This form is used to determine whether you will be assigned another certification period. You have the right to file this recertification application **IMMEDIATELY** as long as it contains your name, address, and signature of a responsible household member **OR** the household's authorized representative. **YOU MAY GET FOOD STAMPS WITHIN SEVEN (7) DAYS** of the **RECERTIFICATION APPLICATION DATE** or on the **FIRST (1ST) DAY OF THE NEW CERTIFICATION PERIOD, WHICHEVER IS LATER - - ONLY** if any of the following exists:1) Monthly rent/mortgage and utilities are more than your household's gross monthly income and liquid assets; 2) Gross monthly income is less than $150 and your household's assets such as cash and checking/savings accounts, are $100 or less; or 3) You are a migrant or seasonal farm worker. You must also complete an interview to determine whether you will be assigned another certification period. A face-to-face interview can be waived for hardship situations as determined by the county.

Signature_____Date_____

Address_____

AUTHORIZED REPRESENTATIVE: You can authorize someone outside your household to get your food stamps for you or to use them to buy food for you. If you would like to authorize someone, provide name, address, and telephone number.

Name_____Address_____Telephone Number_____

CHANGE OF ADDRESS	
VERIFICATION OF RESIDENCE AND UTILITY BILLS ARE REQUIRED FOR FOOD STAMP HOUSEHOLDS ONLY	
Have you moved since your last report? ☐Yes ☐No	If yes, new address:
Mailing address if different:	Date moved:

HOUSEHOLD MEMBERS

Starting with yourself, list everyone that lives with you.

NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE

HEAD OF HOUSEHOLD: If there is more than one parent of a child in the household, list the name of the parent who will be considered the head of the household for food stamp purposes._____

Has anyone moved into or out of your household, or do you expect anyone to move in? ☐Yes ☐No	If Yes, please complete the following:

Name:	Social Security Number:	Birth date:	
Date person entered or left household:	Relationship:	Racial Heritage: (optional)	U.S. Citizen ☐ Yes ☐ No

FOOD STAMP HOUSEHOLDS ONLY
CRIMINAL HISTORY INQUIRY

Have you or any member of your household been convicted of buying or selling food stamp benefits of $500 or more? ☐ Yes ☐ No

Have you or any member of your household, since August 22, 1996, been found to have fraudulently represented his or her identity or place of residence in order to receive multiple food stamp benefits? ☐ Yes ☐ No

If yes, enter date of conviction:	State:	County:

Are you or any member of your household subject to an arrest warrant issued by an authority outside North Dakota's jurisdiction? ☐ Yes ☐ No

If yes, enter date of warrant:	State:	County:

Have you or any member of your household been convicted of any crime for which jail or parole time remains to be served? ☐ Yes ☐ No

If yes, enter date of conviction:	State:	County:

Have you or any member of your household been convicted of a felony for possession, use, or distribution of a controlled substance after August 22, 1996? ☐ Yes ☐ No

If yes, enter date of conviction:	State:	County:

SCHOOL STATUS

Is anyone **age 16 or older** currently attending school, boarding school, college or training? ☐ Yes ☐ No If yes, complete this section. When a new school term begins **Food Stamp households** must provide verification of award letter and school related expenses.

Name	Name of School or Training Site	Grade Level

Does anyone age 16 or older expect a change in school status? ☐ Yes ☐ No
If yes, explain_____

INCOME INFORMATION

UNEARNED INCOME:

This section must be completed for each household member including all children and stepparents. Check each item "yes" or "no." If "yes," show the amount received, who received it, date received, and attach verification. The amount must be shown for both **LAST MONTH** and **NEXT MONTH**.

				LAST MONTH		NEXT MONTH	
	Yes	**No**	**Owner**	**Amount**	**Date(s)**	**Amount**	**Date(s)**
TANF (formerly AFDC)							
Alimony/Child Support							
BIA General Assistance							
Bingo/Gambling Winning							
Individual Indian Monies (IIM)							
Interest/Dividend Income							
Money from Friends, Relatives or Others							
Retirement (Type):							
Rental Income/Contract for Deed							
Social Security							
Supplemental Security Income (SSI)							
Unemployment Benefits							
Veterans Benefits/Military Allotment							
Worker's Compensation							
Other (List Type)							
Has anyone applied for benefits not yet received? (For example: Social Security, SSI, Workers Comp) ☐ Yes ☐ No					If Yes, please explain:		

EARNED INCOME(Wages or Salary):

Is any household member (including children) working? ☐ Yes ☐ No If yes, complete this section. List information about full-time, part-time, seasonal, or temporary employment for all household members. If space is needed to list more jobs, enter them on a separate sheet of paper. The amount must be shown for both **LAST MONTH** and **NEXT MONTH**. **PROOF OF ALL INCOME MUST BE PROVIDED.**

Household Member's Name	Employer's Name	Gross Amount for	Hours Worked Per Week	Salary/ Hourly Wage	Amount of Tips/ Commission	How Often Paid	Day(s) of Week/ Month Paid	Date of Next Paycheck

NEXT MONTH:

Has anyone's employment stopped or had a reduction in hours since your last report? ☐ Yes ☐ No	If Yes, Who_____	
Last day of work?	Was the person: ☐ Laid Off ☐ Fired ☐ Quit ☐ Other	Why?_____
When did this person receive their last paycheck?_____ **Verification Must be Provided**.		
Has anyone started employment since last report? ☐ Yes ☐ No		
If yes, Who_____ When_____ Where_____		
When will the first check be received?_____	How often paid?_____	

SELF EMPLOYMENT:

Is any household member self-employed? ☐ Yes ☐ No	
If yes, name of business:	Type of business:
A complete copy of the most current Federal Income Tax Return must be provided. If you do not have a current tax return that includes the self employment business, provide income and expense ledgers.	
Does anyone in your household expect a change in self employment income **NEXT MONTH?** ☐ Yes ☐ No If yes, explain_____	

ASSET INFORMATION

If you or anyone in your household are in receipt of Food Stamps or Medicaid for someone who is disabled or is age 65 or older, you must complete the entire 'Asset Information' section. All other families with minor children (under age 21) and pregnant women only need to say whether household assets are higher than $3000 for a household of one or $6000 for a household of two (add $25 for every household member over two). Do not include one vehicle, your home, your clothing or household goods, or real property used as part of your job.

☐ Yes, my household assets exceed the amounts listed. **(Go to page 6)**

☐ No, my household assets do not exceed the amounts listed. **(Go to page 6)**

Your answer will not affect your eligibility for Health Care Coverage but may help the state get additional federal money to pay for health care programs.

CHECKING/SAVINGS/OTHER LIQUID ASSETS:

List all cash, checking, savings, certificates of deposit, IRA's, annuities, burial accounts, etc. owned by anyone in your household. (Include all assets owned jointly with another person even if they do not live with you.) Provide current verification of all accounts.

NAME(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT	TODAY'S BALANCE

Has anyone made arrangements for funeral expenses or given money, property, or insurance to someone else to pay for funeral expenses for any household member? ☐ Yes ☐ No

If yes, explain:

OTHER ASSETS:

Did anyone in your household **receive, buy or inherit any assets or sell, give away, or transfer any assets** such as cash, land, buildings, mobile home, contract for deed, mineral acres, life insurance proceeds, stocks, bonds, burial account, trust account, IRA or KEOGH plan, livestock, vehicles, machinery, tools, etc. in the last 3 months for Food Stamps and 12 months for Health Care Coverage? ☐ Yes ☐ No

If yes, explain and provide verification:	Date:

LIFE INSURANCE: (Not required for Food Stamp only cases)

Does anyone have life insurance? ☐ Yes ☐ No If yes, complete the following:

NAME AND ADDRESS OF COMPANY	FACE VALUE	CASH VALUE	OWNER OF POLICY	NAME OF PERSON INSURED	POLICY NUMBER

VEHICLES:

OWNER'S NAME	YEAR	MAKE/ MODEL	LICENSED (Yes/No)	STATE LICENSED IN	VALUE	AMOUNT OWED
					$	$

EXPENSES

FOOD STAMP HOUSEHOLDS ONLY

Does your household have any of the following expenses? Check yes or no for each item and list amounts. **Proof of expenses must be provided.** You will not receive a deduction for any allowable expense you fail to report and verify.

CURRENT EXPENSES	YES	NO	Total Amount	Amount You Pay
Rent/Mortgage (circle one)				
Lot Rent				
Do you pay separately for the use of a garage?				
Is anyone working off any part of the rent?				
Does any government agency pay any part of your rent?				
Property taxes (not included in mortgage)				
Homeowners Insurance (not included in the mortgage)				
Electricity				
Air conditioning costs?				
Heating costs (gas/propane/electric, etc.)				
Do you receive or intend to apply for fuel assistance (LIHEAP)?				
Water/Well installation or maintenance				
Sewer/Septic tank installation or maintenance				
Garbage				
Telephone				

AGENCY USE
Household is entitled to one of the following mandatory utility standards: ☐ HL SU (Heating/Cooling/LIHEAP) ☐ MU (water, sewer, garbage, electricity) ☐ LU SA (Water, sewer, garbage, electricity, telephone) ☐ TL (Telephone only)

Health insurance premiums (list only for persons age 60 or over or who receive disability benefits)				
Medical expenses (list only for persons age 60 or over or who receive disability benefits)				

Do you expect any changes in expenses next month? ☐ Yes ☐ No

If yes, please explain:

Does anyone help you pay these expenses? ☐ Yes ☐ No

If yes, please list what expenses, who is paying, and how much is paid:

EXPENSES

Proof of expenses must be provided. You will not receive a deduction for any allowable expense you fail to report and verify.

Does any household member pay court ordered child support, health insurance premiums, or vendor payments? ☐ Yes ☐ No		
Who are the payments for:	Court ordered amount:	Amount you pay:
Does your household have child care expenses? ☐ Yes ☐ No	Billed amount:	Amount you pay:
Are you receiving Child Care Assistance? ☐ Yes ☐ No	Have you applied for Child Care Assistance? ☐ Yes ☐ No	
Do you expect any changes in these expenses next month? ☐ Yes ☐ No	If yes, please explain:	
Does anyone help you pay any of these expenses? ☐ Yes ☐ No	If yes, please list what expenses, who is paying, and how much is paid:	
List any household members that have a Medicare approved drug discount card:	List the amount of any credit received on your Medicare approved drug discount card.	

HEALTH INSURANCE

Has anyone's health insurance coverage changed since your last report? ☐ Yes ☐ No If yes, complete the following:

Person(s) Covered	Policy Holder Name and Address	Health Insurance Name and Address	* Type of Coverage	Effective Date	Policy Number	Group Number	Monthly Premium

*** Types of Coverage: (List all that apply)**

A - Hospital	**E - Vision**	**I - HMO Insurance**	**M - Medicare Supplement**	**V - Veteran's**
B - Doctor	**F - Nursing Home**	**J - Court Ordered**	**N - Drug Insurance**	
C - Major Medical/Lab/Xray	**G - Cancer**	**K - Medicare part A**	**P - Accident**	
D - Dental	**H - Champus/TriCare**	**L - Medicare part B**	**P - Worker's Compensation**	

Does anyone outside of the household pay the premium? ☐ Yes ☐ No	If yes, who:
Does anyone expect any changes in health insurance coverage? ☐ Yes ☐ No	If yes, explain:

CARING FOR CHILDREN

If children listed on this application are not eligible for Health Care Coverage through the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. This program is offered by a private nonprofit organization, the North Dakota Caring Foundation.

If you have children who are not eligible for Health Care Coverage through Medicaid or Healthy Steps, information from this application needed to determine eligibility for the Caring for Children program, will be sent to them. This allows them to determine eligibility for the Caring for children program. If you do not want us to send the information to the North Dakota Caring Foundation please check below:

☐ Check here if you **do not** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services or county social services does not determine eligibility for the Caring for Children program and any decision regarding this program must be appealed to the North Dakota Caring Foundation.

INFORMATION AND REFERRAL

If my household is eligible for TANF I & R Services, my household has been notified and authorized to receive TANF Information and Referral Services.

PLEASE READ

- In addition to completing this form, **You must report changes that could affect eligibility within 10 days** from the time you learn of the change.
- Household benefits may be increased, reduced, terminated, or remain unchanged as a result of the answers you give on this report. You will be notified in writing of changes and the reason for such change.
- This report will be considered incomplete if not signed, all questions are not answered, or all applicable verifications are not attached.
- 42 U.S.C. 1320b-7 requires all persons requesting assistance to provide their social security number or show that they have applied for one; failure to provide this information will cause the person to be ineligible for assistance. The social security number is used to check the identity of household members, to prevent duplicate participation, to monitor compliance with program regulations, for claim collection, for official examinations by Federal and State agencies, and to help make mass changes. The social security number is also used to check information in our records and against other Federal, State and local government computer matching systems participating in the Income and Eligibility Verification System, including but not limited to the IRS, SSA, Department of Labor and TANF, which may affect eligibility and level of benefits. Use of social security numbers provided for Food Stamp benefits may be disclosed to law enforcement for purposes of apprehending fleeing felons.
- State and Federal Laws provide for a fine and/or imprisonment for any person who fraudulently receives or attempts to receive assistance to which he/she is not entitled.
- The alien status of any household member may be subject to verification by the Immigration and Naturalization Service (INS) through the submission of information from the application to INS, and that the information received from INS may affect the household's eligibility and level of benefits.
- Equal treatment. In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers**.**

PENALTY WARNING FOR FOOD STAMP RECIPIENTS

- **FOOD STAMP PROGRAM**

  Do not give false, inaccurate, or incomplete information.
  Do not buy ineligible items such as alcohol or tobacco with Food stamp benefits
  Do not trade or sell your EBT card.
  Do not use or have in your possession other people's EBT cards or Food Stamp benefits.

Any member of your household may be removed from the Food Stamp Program for:

- One year for violating a Food Stamp rule;
- Two years for a second violation; or first conviction for buying, selling, or trading Food Stamps for a controlled substance.
- Ten years for a conviction for making a fraudulent statement with respect to identity or representation with respect to identity or place of residence in order to receive multiple benefits simultaneously.
- Lifetime for violating a Food Stamp rule a third time; or a second conviction for buying, selling, or trading Food Stamps for a controlled substance; convicted of buying or selling Food Stamp benefits of $500 or more. If a court of law finds a household member guilty of trading Food Stamps for firearms, ammunition, or explosives, the individual is permanently barred from the program.
- In addition, any household member may be removed by a court for an additional 18 months; or prosecuted and fined up to $250,000 or imprisoned up to 20 years or both.
- A Food Stamp recipient who is subject to the work requirements that fails to comply with those requirement may lose Food Stamp benefits.

Receiving Food Stamp or Health Care Coverage benefits has no bearing on any other programs time limits that may apply to your household. If you are applying for or already receiving TANF benefits, the time limits and other requirements that apply to receipt of TANF do not apply to receipt of Food Stamp or Health Care Coverage benefits. If you no longer receive TANF or if your case is closed for TANF because of the lifetime limit, because you started work, or for some other reason, you may still qualify for Food Stamp and Health Care Coverage benefits.

AUTHORIZATION TO RELEASE INFORMATION

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I authorize the North Dakota Department of Human Services and carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until assistance ends or until revoked in writing. A copy of this authorization is as valid as the original.

SIGNATURE

I certify under penalty of perjury, that the information contained on this report is true, including the information concerning citizenship and alien status of members applying for benefits.

You or your authorized representative may request a fair hearing orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose. We will consider this report without regard to race, color, sex, handicap, religion, national origin or political belief.	**SIGNATURE**	**DATE**
	TELEPHONE NUMBER	
	WITNESS IF YOU SIGNED WITH AN X	